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The health of refugees and displaced persons in South Sudan

J. Wamala

Ministry of Health, Juba, South Sudan

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Managing health and infections in refugees: Turkey's experience

H. Leblebicioglu

Ondokuz Mayis University Medical School, Samsun, Turkey

Abstract: Turkey is located adjacent to the regions of war and crisis. After the outbreak of conflicts in Syria on March 2011, over 4.5 million people have been forced to leave their country and over 2,200,000 of them took refuge in Turkey. Turkish government has implemented "open-door policy" and shouldered a tremendous load collaborating with non-governmental organizations and spent nearly $8 billion for caring of refugee population. Refugees were first met at border crossing points, registered and given identity cards that document the status of "temporary protection". A symptom-based screening (not a standard protocol) was implemented for urgent health problems during registration and children were included in the national vaccination program comprising oral polio, measles (MMR),TdaP-HiB-IPV(quintet vaccine), hepatitis-B and conjugated pneumococcus.

As of January 4, 2016; 267,476 refugees are placed in 25 separate accommodation centers in ten different cities and remaining majority of refugees live out of the camps. Although health and education facilities are better in the camps, those non-camp residents also have free access to primary care and even secondary or tertiary-care if address-based registry was made and complied to the referral chain. Mop-up vaccination campaigns are launched for non-camp residents scattered in large cities and the coverage has extended above 90 percent for polio and measles. Healthcare capacity for refugees/asylum seekers was re-established by recent regulations on the basis of "Law on foreigners and international protection" that has entered into force on 11 April 2014. According to the current legislation; medical requirements of Syrian refugees including medicine, dentures, eyeglasses, hearing aids and similar medical materials are provided, treatment costs are to be billed to the Governor of the relevant province.

A significant number of the refugees suffer physical and psychological traumas of the war while infections are not among the leading health problems. According to the records of Ministry of Health; 5505 cases of cutaneous leismaniasis and 558 cases of tuberculosis were detected and treated (in and out of the camps) as of October 2015. Tuberculosis was screened in 10,689 refugees and the prevalence was found to be similar to the Turkish population (18.7/100 000). Screening was terminated. No case of malaria was detected in the blood smears of over 100,000 people. A significant increase was detected in cases of measles, particularly in southeastern region where the camps are located. This caused a shift in national vaccination program and the booster of MMR vaccine was withdrawn from the first year of primary school to the preschool period.

Breakdown of healthcare infrastructure, shortage of medical personnel, medical supply and drugs, limited access to clean water and problems with garbage disposal had lead to outbreaks of hepatitis A, typhoid fever and cholera in Syria. Increasing number of cutaneous leishmaniasis cases in Turkey and Lebanon, tuberculosis in Lebanon and Jordan among refugees was reported. Overall due to the lack of infrastructure of health care system in Syria, increasing number of refugees and overcrowded camps with suboptimal sanitation conditions in Lebanon and Iraq, these emerging and re-emerging pathogens not only threat the refugees but also effect the citizens of Middle East countries and even Europe. Therefore there is an urgent need of international collaboration between United Unions, European Union, governments, WHO, CDC, ECDC, humanitarian organizations, funding bodies and pharmaceutical companies to cope with infectious diseases, humanitarian crisis and recover health care and public health system in Syria.

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Rapid diagnostic point of care tests in resource limited settings

J. Kafkova

St. Raphael Clinic, Nairobi, Kenya

Abstract: One of the definitions of diagnostic point of care testing is provision of laboratory testing at or near the site of patient care. It has the potential to minimise the time to obtain the result of the test, which expedites the diagnosis and initiation of the treatment especially in resource-limited settings where health care infrastructure is weak and access to quality and timely medical care represents a challenge. It is estimated, that introduction of rapid, laboratory-independent diagnostic tests for four

diseases (syphilis, malaria, tuberculosis and bacterial pneumonia) in developing countries could prevent more than 1.2 million deaths annually. In resource-limited settings, laboratory medicine is still one of the most neglected pillars of the health care. In such settings, primary health care services largely depend on diagnostic point of care testing; therefore the benefits need to overweight the costs. To optimise the diagnostic point-of-care, there is a need for strict evaluation focused on relevant clinical outcomes and operational costs and these evaluations differ from the conventional tests. However, there is no consistent, standardized approach to assess the point-of-care testing technologies in resource-limited settings. Diagnostic point-of-care testing possesses significant importance in infections like TB or HIV, because it eliminates the long turn-around times and delays and the resulting loss of patients from the testing and therapy pathway. An ideal rapid diagnostic point-of-care test used in resource-limited settings should fulfil the following criteria: allowing a quick clinical decision, can be used by a health care worker (possibly by a nonprofessional), affordable, rapid, acceptable test efficacy, and cost effectiveness.

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Infectious diseases in refugees and migrants during the European Migrant Crisis 2015

V. Krcmery

St. Elizabeth University College of Health and Social Sciences, Bratislava, Slovakia

Abstract: Migrant Crisis in Europe 2015 had two major routes, Balkan route via Greece, Hungary, Austria to Germany and African route with mainly economic refugees and migrants via Mediterranean Malta Lampedusa, Sicily to continental Italy, France, Spain and UK. Here we present first data on migrant health of the Balkan route from September to October 2015.

About 316 000 political and humanitarian refugees, 95% from Syria, Iraq and Afganistan passed through checkpoint Hegyeshalom, Nickelsdorf 50 km east from Vienna and 10 km from Bratislava, between September 6th and October 20th. Most of them were healthy young people with children, about 10 percent sick per transport, in 97 trains from Zakanyi Croatian Boundary or Röszke, HU- Serbian Boundary to Hegyeshalom, Nickelsdorf HU, AT checkpoint. Sick patient's reported themselves to the symptomatic field heath center with 8-12 HC Tropicteam staff serving in 5 languages. In RTI patients, nasal/tonsil swabs was taken to Mueller Hinton agar and transported to National reference Laboratory for ATB resistance, Nitra, SK.

No major tropical diseases were noted, no case of malaria or leishmaniasis was detected. Even less cases of emerging ID including HIV and tuberculosis were detected as well. Majority of ID included pneumonia upper respiratory tract infections, skin and soft tissue infections, scabies, few cases (<3%) of diarrhoea but no case of cholera have been observed in described period. Among acute cases, diabetic coma, myocardial infarction, hypertension crisis and has been noted. From 155 positive results from bacteriology from migrants, only 2 MRSA strains and 3 penicillin resistant pneumococci were obtained, the rest was commensal bacterial flora and Candida albicans.

Balkan route in refugee crisis in 2016 in Europe from Syria, Iraq does not represent major health threat to continental EU, only few cases of transmissible diseases were noted and an absence of tropical diseases, multiresistant pathogens and no outbreaks were observed within first 2 months of exodus. Only few MRSA and penicillin resistant strains from patients from upper and lower respiratory tract infections were isolated. Spectrum of diagnoses was similar to surrounding Slovak, Hungarian and Austrian population of that EU region.

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From evidence to impact: Improving treatment for Kala Azar patients in India

R. Mahajan[1,*], T. Sunyoto[2], K. Malakyan[3], G. Mitra[1], D. Kumar[4], M.A. Lima[5], P. Mathew[2], S. Burza[1]

[1] *Medecins Sans Frontieres, Delhi, New Delhi, India*
[2] *Medecins Sans frontieres, New Delhi, India*
[3] *medecins sand Frontieres, New Delhi, India*
[4] *Medecins Sans Frontieres, hajipur, India*
[5] *Medecins Sans Frontieres, Barcelona, Spain*

Background: Visceral leishmaniasis (VL), or Kala-Azar is a life-threatening systemic infection caused by protozoan *Leishmania*, with sand flies as its vectors affecting the poorest of the poor people. India bears 50% of global VL burden and was committed to eliminate VL elimination by 2015. New treatment modalities were proposed by WHO since 2010, yet first line treatment in India has remained unchanged since 2006. The 2014 release of India National Road Map of Kala azar Elimination marked a milestone in the progress towards the elimination goal: Single Dose liposomal amphotericin B (Ambisome®) or SDA was adopted in the national programme. Role of evidence in the policy change is explored.

Methods & Materials: Médecins Sans Frontières (MSF) started a VL treatment programme in Bihar, India since 2007, using 20 mg/kg intravenous Ambisome and treated over 11,000 patients with excellent results. With lack of high quality evidence, a phase 4 trial of new treatment modalities including SDA was commenced in August 2012 by MSF, Drug for Neglected disease initiative (DNDi) and Rajendra Memorial research Institute (RMRI). Effectiveness and safety data presented in December 2013. Additionally, a qualitative study to determine patient perspectives of these new treatments was conducted. At the same time, advocacy wise, a successful negotiation with Gilead as Ambisome producer has led to free donation of the drug to the Indian Government, further facilitating the process towards policy change.

Results: By supporting MoH facilities in implementing alternative regimen such as Ambisome, MSF demonstrated its feasibility at different level of health care, including primary health centres. Evidence from formal trial is indispensable; however, debunking the perception that such a 'complex' treatment could not be implemented as first line treatment was as important. Various factors